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Chairman Camp, Ranking Member Levin, and Members of the Committee, thank you for the opportunity to speak with you today.

The focus of today's hearing is the Affordable Care Act's employer responsibility provisions: in particular, the definition of full-time work as 30 hours or more per week. Determining who is a full-time worker under the ACA is important because the ACA requires large firms – defined as those with 50 or more full-time or full-time equivalent (FTE) workers – to offer affordable health insurance only to full-time workers. Part-time workers can be excluded from a large firm's health insurance plan without any risk of triggering employer penalties under Section 4980H of the ACA.

The concern that Chairman Camp and others have raised is that this definition of full-time could create an incentive for firms to keep workers' hours below 30, and that a large number of workers could be stuck just below this threshold. There is considerable evidence, however, that this concern has been overstated, and that one proposed change – increasing the full-time threshold to 40 hours – would in fact exacerbate the potential problem considerably.

The best evidence we have on the labor market impact of an insurance mandate with an hours threshold comes from Hawaii. Since the mid-1970s, Hawaii has required employers of all sizes to provide coverage to employees who work 20 hours or more per week. A recent study finds that over time, this requirement has resulted in significantly higher rates of employer-sponsored coverage for Hawaiian workers compared with other US workers, has had no significant effect on overall employment, and has caused a small increase in the probability of part-time work.[1] The effect on part-time work represents an increase of 1.4 percentage points in the fraction of employment that is part-time. To put that number in perspective: currently about 19% of workers nationally are part-time.[2]

Hawaii is an unusual state in many ways, and it is important to keep in mind that the mandate in Hawaii may have been more distortionary for labor demand than the ACA mandate. An important reason is that it requires employers to provide insurance to part-time workers, which they generally would not otherwise do. In contrast, the majority of workers who meet the ACA's definition of full-time already receive health benefits. Nonetheless, many observers are now looking to Hawaii for evidence on the impact of the hours threshold, and the evidence suggests that their mandate had no effect on overall employment and caused only a small shift toward part-time work.

At the national level, given a civilian workforce of not quite 150 million people, even a small shift is a lot of people. Part of the difficulty in our national conversation about whether the effects of policy are big or small seems to be confusion about whether we should focus on the *fraction* of workers affected or

[1] Buchmueller, Thomas C., John DiNardo, and Robert G. Valletta. "The effect of an employer health insurance mandate on health insurance coverage and the demand for labor: Evidence from Hawaii." American Economic Journal: Economic Policy 3, no. 4 (2011): 25-51.

[2] US Department of Labor, Bureau of Labor Statistics, "The Employment Situation – December 2013," USDL-14-002, released January 10, 2014.

the *number* affected. In this case, the fraction is small; but the number is big, and so it will always be possible to find individuals who are affected by these changes. I do not mean to dismiss the economic or emotional resonance of the stories about workers whose employers say that they are cutting hours to hold down costs - just as I would not dismiss the resonance of stories about individuals helped by gaining secure coverage as a result of the Affordable Care Act, if those were the stories that the Committee had chosen to hear today.

Because of concern over the potential distortion in labor demand (i.e. cutbacks in hours) associated with the 30 hour rule, there have been proposals to shift the cutoff to 40 hours instead. After all, workers at this higher threshold are more likely than those working 30 hours to have health insurance coverage from their employers already, meaning they are not at risk of having their hours cut so the firm can avoid giving them insurance. But this approach does not actually solve the problem; it just moves it. And in moving it, the problem becomes much bigger.

Here's why: there are many more uninsured workers who work 40 hours than 30. Three recent independent analyses that have looked at this issue have all reached this same basic conclusion.[3,4,5] If you consider full-year workers in large firms who currently do not have insurance, about 850,000 of them currently work between 30 and 34 hours; but 2.6 million of them work 40 to 44 hours.[6] So the bottom-line effect of changing the full-time threshold to 40 hours would be to place many more workers at risk of having their hours cut. This change would also increase Federal spending on Medicaid and premium tax credits.[7]

Thinking beyond the 30 hour rule, we might also ask how the coverage provisions of the ACA as a whole are likely to affect the labor market. The 30 hour rule and the employer responsibility provisions are part of a larger policy that creates a viable health insurance market for those who do not have access to affordable employer-sponsored coverage. The exchanges, the insurance market regulations, the premium tax credits, the employer mandate, and the individual mandate are all in service of this larger goal.

Health care reform is likely to have important benefits for labor markets, by alleviating various forms of "job-lock." The ability to obtain affordable insurance without working full-time for a large firm will make it easier for entrepreneurs to start their own businesses. One recent study of older men shows that there is a jump of several percentage points in the rate of business ownership among men at age 65 when they become eligible for Medicare, which suggests that before this point they had been holding

[3] Ken Jacobs and Dave Graham-Squire, "Under the "Forty Hours is Full Time Act" more Americans would lose job-based health coverage and work hours, while federal costs would increase," UC Berkeley Center for Labor Research and Education, December 2013.
[4] Paul N. Van de Water, "Health Reform Not Causing Significant Shift to Part-Time Work But Raising Threshold to 40 Hours a Week Would Make a Sizeable Shift Likely," Center on Budget and Policy Priorities, October 12, 2013
[5] Sherry Glied and Claudia Solis-Roman, "Why Changing the Definition of Full-Time Work Under the ACA Will Put More Workers at Risk and Increase Federal Spending," Commonwealth Fund blog post, January 24, 2014
[6] *Ibid*, Glied and Solis-Roman
[7] *Ibid*, Jacobs and Graham-Squire

back because of the lack of health insurance alternatives.[8] The Affordable Care Act removes these frictions for workers of all ages. Today, many parents with young children or older workers nearing retirement would like to work part-time, but are unable to because they need to work full-time to qualify for health insurance. Because of the ACA, such workers will be able to choose the schedules they prefer.

Our best evidence on the overall labor market impact of such a bundle of reforms comes from Massachusetts, where comprehensive reform similar to the Affordable Care Act was implemented in 2007. The evidence from Massachusetts is clear: there was no decline in employment or hours relative to neighboring states, even in industries that are generally low-wage such as accommodation, food services, and retail.[9] Of course, Massachusetts is not a typical state and their reform was not exactly like the ACA. In some ways it was more stringent; the employer mandate in Massachusetts applied to firms with as few as 11 workers compared with 50 in the ACA. In other ways it was less stringent; the penalties for not offering insurance were smaller than those in the ACA. Nonetheless, the Massachusetts experience strongly supports the view that comprehensive health reform with an employer mandate does not kill jobs.

Why does the evidence show no decline in hours or employment, given the strong theoretical prediction of distortions in labor demand? One reason is that employers can reduce wages to offset at least some of the increased health insurance costs that they face as a result of the employer responsibility provisions. Indeed, research shows that this is exactly what happened in Massachusetts.[10] This is an important mechanism through which employers can respond to the distortion created by the regulation, and it minimizes the impact on labor demand. The mandate affects only one component of employment cost. Nationally, health insurance currently accounts for about 8% of the cost of compensation in private industry, compared with 70% for wages and salaries.[11] Thus, except in cases where the minimum wage is a binding constraint, an increase in the cost of health insurance can be at least partially absorbed by reductions in wage growth.

Moreover, at the national level, the size threshold for the employer mandate - 50 workers – has been set at a level where the great majority of employers are already offering coverage. Among firms with 50 to 199 workers, 91 percent already offer insurance; among firms with 200 or more workers the figure is 99 percent.[12] If nearly all large employers are already providing insurance voluntarily, the distortion in labor demand as a result of the mandate is, by definition, limited to a very small minority of firms.

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[8] Fairlie, Robert W., Kanika Kapur, and Susan Gates. "Is employer-based health insurance a barrier to entrepreneurship?" Journal of Health Economics 30, no. 1 (2011): 146-162.

[9] Lisa Dubay, Sharon K. Long, and Emily Lawton, "Will Health Reform Lead to Job Loss? Evidence from Massachusetts Says No," Urban Institute, June 2012.

[10] Jonathan T. Kolstad and Amanda E. Kowalski, "Mandate-Based Health Reform and the Labor Market: Evidence from the Massachusetts Reform," National Bureau of Economic Research Working Paper 17933, March 2012.

[11] US Department of Labor, Bureau of Labor Statistics, Employer Costs for Employee Compensation - September 2013. Released December 11, 2013.

[12] Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2013.

The Congressional Budget Office has projected that the ACA would reduce employment in 2021 by about one half of one percent.[13] If this were an estimate of the increase in the number of individuals *involuntarily unemployed* as a result of the ACA, it would be alarming, but *this is not the correct interpretation of CBO's projection*. CBO is very clear that most of this effect is due to changes in labor *supply*, or the amount that workers choose to work, not labor *demand,* which is the amount of labor firms want to hire. CBO did not elaborate on the exact nature of the labor supply changes that ACA might cause. But one example of a change in labor supply would be older workers switching to voluntary part-time work, as discussed above. From an economic perspective, and from the perspective of common sense, it is inaccurate to characterize such voluntary reductions in labor supply as "job killing."

To summarize: the best evidence that we have suggests that the ACA – including the 30 hour rule - is likely to have very little effect on labor demand, relative to the size of the labor market. Moreover, the evidence suggests that there may be significant positive effects on the labor market, primarily through the alleviation of job lock. Any costs to the labor market must be weighed against the benefits that the ACA offers not only for the millions of uninsured who will gain coverage, but also for labor markets.

I thank you for your attention, and I look forward to answering any questions you may have.

[13] Statement of Douglas W. Elmendorf, Director, Congressional Budget Office, "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010," before the Subcommittee on Health Committee on Energy and Commerce, U.S. House of Representatives, March 30, 2011.